		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041640

Facility Name: HEARTLAND HLTH CR CTR-PAXTON

Address: 1001 East Pells Street (Number) Paxton (City) 60957 (Zip Code)

County: Ford

Telephone Number: (217) 379-4361 **Fax #** (217) 379-3325

IDPA ID Number: 344402510014

Date of Initial License for Current Owners: 10/03/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President of Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,755	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	87	TOTALS	87	31,755	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		6,340	4,362	10,702	8
9	SNF/PED					9
10	ICF	1,637	18,730		20,367	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,637	25,070	4,362	31,069	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.84%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/03/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 4,007

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	148,889	15,858	11,600	176,347	1,361	177,708		177,708			1
2	Food Purchase		129,222		129,222		129,222	(10,331)	118,891			2
3	Housekeeping	87,747	9,386	161	97,294		97,294		97,294			3
4	Laundry	30,729	7,349		38,078		38,078		38,078			4
5	Heat and Other Utilities			91,665	91,665	4,958	96,623	(8,352)	88,271			5
6	Maintenance	33,853	11,268	46,007	91,128		91,128		91,128			6
7	Other (specify):* Med Waste			1,253	1,253		1,253		1,253			7
8	**TOTAL General Services**	301,218	173,083	150,686	624,987	6,319	631,306	(18,683)	612,623			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,346,192	62,480	31,671	1,440,343	29,249	1,469,592	(3,256)	1,466,336			10
10a	Therapy	179,325	3,178	7,736	190,239		190,239		190,239			10a
11	Activities	64,552	3,795	1,793	70,140		70,140		70,140			11
12	Social Services	57,515		1,357	58,872		58,872		58,872			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,647,584	69,453	55,757	1,772,794	29,249	1,802,043	(3,256)	1,798,787			16
	C. General Administration											
17	Administrative	112,305		243,175	355,480	(91,343)	264,137		264,137			17
18	Directors Fees											18
19	Professional Services			1,140	1,140	(1,000)	140	(140)				19
20	Dues, Fees, Subscriptions & Promotions			41,991	41,991		41,991	(22,849)	19,142			20
21	Clerical & General Office Expenses	111,000	42,752	19,077	172,829	1,000	173,829	(11,752)	162,077			21
22	Employee Benefits & Payroll Taxes			519,248	519,248	32,994	552,242		552,242			22
23	Inservice Training & Education			5,375	5,375		5,375		5,375			23
24	Travel and Seminar			23,055	23,055		23,055		23,055			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			92,287	92,287		92,287		92,287			26
27	Other (specify):*											27
28	**TOTAL General Administration**	223,305	42,752	945,348	1,211,405	(58,349)	1,153,056	(34,741)	1,118,315			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,172,107	285,288	1,151,791	3,609,186	(22,781)	3,586,405	(56,680)	3,529,725			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON #0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			252,589	252,589	17,879	270,468		270,468			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,541	31,541	4,902	36,443	(443)	36,000			32
33	Real Estate Taxes			60,217	60,217		60,217	(8,025)	52,192			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,947	15,947		15,947		15,947			35
36	Other (specify):*											36
37	**TOTAL Ownership**			360,294	360,294	22,781	383,075	(8,468)	374,607			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		88,854	18,851	107,705		107,705		107,705			39
40	Barber and Beauty Shops		470	13,580	14,050		14,050		14,050			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,633	47,633		47,633		47,633			42
43	Other (specify):* **Therapy Drugs**		13,764		13,764		13,764		13,764			43
44	**TOTAL Special Cost Centers**		103,088	80,064	183,152		183,152		183,152			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,172,107	388,376	1,592,149	4,152,632		4,152,632	(65,148)	4,087,484			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,331)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,352)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(443)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,031)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,541)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(6,236)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(140)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	1,727	21		24
25	Fund Raising, Advertising and Promotional	(22,849)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,025)	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,927)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (65,148)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (65,148)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HEARTLAND HLTH CR CTR-PAXTON

ID# 0041640

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Ambulance	$ (3,256)	10	1
2	G/L Assets-Equity Earned	(2,671)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,927)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,331)	0	0	0	0	0	0	0	0	0	0	(10,331)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(8,352)	0	0	0	0	0	0	0	0	0	0	(8,352)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,683)	0	0	0	0	0	0	0	0	0	0	(18,683)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,256)	0	0	0	0	0	0	0	0	0	0	(3,256)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,256)	0	0	0	0	0	0	0	0	0	0	(3,256)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(140)	0	0	0	0	0	0	0	0	0	0	(140)	19
20	Fees, Subscriptions & Promotions	(22,849)	0	0	0	0	0	0	0	0	0	0	(22,849)	20
21	Clerical & General Office Expenses	(11,752)	0	0	0	0	0	0	0	0	0	0	(11,752)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(34,741)	0	0	0	0	0	0	0	0	0	0	(34,741)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,680)	0	0	0	0	0	0	0	0	0	0	(56,680)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(443)	0	0	0	0	0	0	0	0	0	0	(443)	32
33	Real Estate Taxes	(8,025)	0	0	0	0	0	0	0	0	0	0	(8,025)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,468)	0	0	0	0	0	0	0	0	0	0	(8,468)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(65,148)	0	0	0	0	0	0	0	0	0	0	(65,148)	45

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Page 8		$ 243,175	HCR Manor Care, Inc	100.00%	$ 243,175	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V	10a	Therapy Management	6,963	Heartland Management Services	100.00%	6,963		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 250,138			$ 250,138	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac	940,169	509,589	4,139,791	1,361	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac	288,728		4,139,791	497	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac	3,082,391		4,139,791	4,461	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac	11,758,547	7,451,541	4,139,791	20,257	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac	6,213,378	3,630,890	4,139,791	8,992	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac	17,137,345	15,146,077	4,139,791	29,524	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac	84,513,196	36,356,102	4,139,791	122,308	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac	4,283,731		4,139,791	7,380	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac	17,698,741		4,139,791	25,614	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac			4,139,791	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac	12,354,014		4,139,791	17,879	12
13										13
14	32	Interest				11,412,188			4,902	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 169,682,428	$ 63,094,199		$ 243,175	25

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of America *		X	Finance Capital Additions	N/A		$ 618,583	$			$ 3,985	1
2	* Note was paid off during the year											2
3	National City Bank, Trustee		X	Finance Capital Additions	N/A			618,583			27,556	3
4								Home Office Allocation			4,902	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 618,583	$ 618,583			$ 36,443	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 618,583	$ 618,583			$ 36,443	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	68,242	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	60,217	2
3. Under or (over) accrual (line 2 minus line 1).	$	(8,025)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	60,217	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	52,193	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	42,449	8
1999	50,754	9
2000	52,590	10
2001	55,180	11
2002	60,217	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HEARTLAND HLTH CR CTR-PAXTON COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0041640

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-08-476-001	See Attached	$ 30,108.74	$ 30,108.74
2.	11-14-08-476-001	See Attached	$ 30,108.74	$ 30,108.74
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 60,217.48	$ 60,217.48

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,533 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 75,186	1
2					2
3	TOTALS			$ 75,186	3

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	59		1988	1988	$ 1,323,187	$ 43,960		$ 43,960	$	$ 671,119	4
5	20			1998	1,195,198	59,760		59,760		323,644	5
6	8			2001	440,268	11,007		11,007		20,179	6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					54,707		54,707		485,016	9
10	Land/Bldg. Improvement (See attached schedule)			1988	279,229						10
11	Additional Attic Insulation			1989	3,500						11
12	Fire Alarm System			1990	294						12
13	Land/Bldg. Improvement (See attached schedule)			1990	8,348						13
14	Land/Bldg. Improvement (See attached schedule)			1991	6,404						14
15	Land/Bldg. Improvement (See attached schedule)			1992	24,904						15
16	Land/Bldg. Improvement (See attached schedule)			1993	12,778						16
17	Land/Bldg. Improvement (See attached schedule)			1994	1,010						17
18	Land/Bldg. Improvement (See attached schedule)			1995	14,522						18
19	BATHTUB			1996	356						19
20	(7) DOORS			1996	3,896						20
21	WALLCOVERING			1996	1,133						21
22	CARPET & WALLCOVERING			1996	2,199						22
23	CEILING			1997	2,101						23
24	WALLCOVERING			1997	8,139						24
25	WALLCOVERING			1997	22						25
26	CREDIT ON BLD IMP-CNCLD RETAIN			1997	(434)						26
27	WALLCOVERING			1997	13,695						27
28	CARPET			1997	1,081						28
29	WALLCOVERING			1997	1,571						29
30	ENGINEERING AND ARCHITECTURAL FEES			1997	75,055						30
31	(14) PKG AMANA A/C UNITS			1997	9,051						31
32	PAINTING			1997	10,933						32
33	PAINTING & WALLCOVERING			1997	7,933						33
34	NURSE CALL SYSTEM			1997	2,561						34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	VINYL WALL COVERING FROM INVENTORY	1997	$ 293	$		$	$	$	37
38	VINYL WALL COVERING FROM INVENTORY	1997	187						38
39	VINYL WALL COVERING FROM INVENTORY	1997	814						39
40	CUBICLE CURTAIN TRACK	1997	1,416						40
41	NURSE CALL SYSTEM UPGRADE	1997	2,305						41
42	WALLCOVERING	1997	157						42
43	CROWN MOLDING & CHAIR RAIL	1997	820						43
44	GARAGE WOOD	1997	12,983						44
45	ADDL'T COST FOR NURSE CALL SYSTEM #15	1998	167						45
46	WALLCOVERING	1998	191						46
47	COVE BASE	1998	1,529						47
48	WALLCOVERING	1998	75						48
49	DOOR ALARMS	1998	3,598						49
50	WALLCOVERING	1998	249						50
51	SECURE CARE LOCKS	1998	11,971						51
52	ADDL'T NURSE CALL SYSTEM	1998	1,901						52
53	WALLPAPER FROM CONSTRUCTION	1998	196						53
54	GATE	1998	390						54
55	A/C UNIT	1998	1,925						55
56	HVAC FOR ADDITION	1998	47,008						56
57	BRASH BARRY GENERAL CONSTRUCTION	1998	23,132						57
58	REMOVE OVERHEAD PAGING	1998	338						58
59	WALLCOVERING	1998	7,678						59
60	CABINETRY & COUTNERTOPS	1998	8,240						60
61	CARPENTRY	1998	24,126						61
62	ELECTRICAL WORK	1998	444						62
63	ELECTRICAL WORK	1998	32,894						63
64	LIGHT FIXTURES	1998	1,253						64
65	PLUMBING WORK	1998	711						65
66	LAWNCARE SEEDED CONSTRUCTION AREA	1998	440						66
67	SPRINKLER SYSTEM	1998	45,812						67
68	FIRE ALARM SYSTEM	1998	3,370						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,685,547	$ 169,434		$ 169,434	$	$ 1,499,958	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,685,547	$ 169,434		$ 169,434	$	$ 1,499,958	1
2	FENCE	1998	6,507						2
3	PAVING	1998	38,079						3
4	CONSTRUCTION AND DESIGN OVERHEAD COST	1999	114,792						4
5	DIRECT VENT UNIT HEATER	1999	1,556						5
6	SECURE CARE LOCKING SYSTEM	1999	958						6
7	SEAL & STRIPE PARKING LOT	1999	3,136						7
8	EXTERIOR LIGHTING	1999	20,250						8
9	SINK & FAUCET	2000	596						9
10	NURSES STATION	2000	11,790						10
11	COUNTERTOP	2000	1,200						11
12	VCT	2000	1,140						12
13	WATER HEATER	2000	3,780						13
14	NURSES STATION	2000	475						14
15	PAINTING	2000	11,005						15
16	CUSTOM CABINETS	2000	7,091						16
17	INSTALL CARPET	2001	593						17
18	GAZEBO	2001	4,319						18
19	LANDSCAPING-ARCADIA RENOV	2002	21,295						19
20	PAINTING	2002	7,175						20
21	PAINTING	2002	825						21
22	CARPENTRY-ARCADIA RENOV	2002	16,430						22
23	DRAPES	2002	130						23
24	CARPENTRY-ARCADIA RENOV	2002	13,084						24
25	FLOORING, VINYL WALL COVERING	2002	8,405						25
26	OUTDOOR LIGHTING	2002	1,560						26
27	DOORS	2002	5,900						27
28	MDS OFFICE-VINYL WALL COVERING	2003	419						28
29	MDS OFFICE-PAINTING & VINYL WALL COVERING	2003	945						29
30	MDS OFFICE-RETAINAGE-PAINTING & VWC	2003	105						30
31	MDS OFFICE-ELECTRIC WORK	2003	1,338						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,990,425	$ 169,434		$ 169,434	$	$ 1,499,958	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,990,425	$ 169,434		$ 169,434	$	$ 1,499,958	1
2	MDS OFFICE-BORDER	2003	66						2
3	CARPET	2003	1,051						3
4	HALLWAY PAINT & BORDER	2002	1,150						4
5	SNF ADDITION - ARCHITECT COSTS	2003	4,612						5
6	OUTLETS IN DINING ROOM	2003	1,280						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,998,584	$ 169,434		$ 169,434	$	$ 1,499,958	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 986,704	$ 83,156	$ 83,156	$		$ 707,971	71
72	Current Year Purchases	53,809						72
73	Fully Depreciated Assets							73
74	H/O Allocation			17,879	17,879			74
75	TOTALS	$ 1,040,513	$ 83,156	$ 101,035	$ 17,879		$ 707,971	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,114,283	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 252,590	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 270,469	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 17,879	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,207,929	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 15,947 Description: O2 Concentrators, Wheelchairs, Gerichairs, Electric Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2402 hrs	$ 63,734	107	$ 2,675	$ 542	2,509	$ 66,951	1
2	Licensed Speech and Language Development Therapist	10a	619 hrs	16,419	18	443	(7)	637	16,855	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	3738 hrs	99,172	177	4,414	2,643	3,915	106,229	4
5	Physician Care		visits							5
6	Dental Care	39	visits			2,325			2,325	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				88,854		88,854	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S-Lab, Xray, Inhal	39,col 3				16,730			16,730	13
14	TOTAL			$ 179,325	302	$ 26,587	$ 92,032	7,061	$ 297,944	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON **#** 0041640 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 427	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (2,540))	226,360		3
4	Supply Inventory (priced at)	3,679		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	519		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 230,985	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,186		13
14	Buildings, at Historical Cost	3,998,585		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,040,513		16
17	Accumulated Depreciation (book methods)	(2,207,929)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	44,802		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,951,157	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,182,142	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 18,355	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,010		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,217		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	24,380		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 300,962	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	618,583		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 618,583	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 919,545	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,262,597	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,182,142	$	48

***(See instructions.)**

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,403,018	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,403,018	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	615,249	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 615,249	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(755,670)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (755,670)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,262,597	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,164,198	1
2	Discounts and Allowances for all Levels	(281,464)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,882,734	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	713,041	6
7	Oxygen	1,350	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 714,391	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,383	12
13	Barber and Beauty Care	16,862	13
14	Non-Patient Meals	9,426	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,135	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44,343	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,084	21
22	Laundry	3,080	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 170,313	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	332	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 332	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Inc	111	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 111	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,767,881	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	624,987	31
32	Health Care	1,772,794	32
33	General Administration	1,211,405	33
	B. Capital Expense		
34	Ownership	360,294	34
	C. Ancillary Expense		
35	Special Cost Centers	183,152	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,152,632	40
41	**Income before Income Taxes (line 30 minus line 40)****	615,249	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 615,249	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,712	4,053	$ 110,137	$ 27.17	1
2	Assistant Director of Nursing	3,754	4,100	94,238	22.98	2
3	Registered Nurses	10,250	11,192	228,723	20.44	3
4	Licensed Practical Nurses	13,717	14,979	246,412	16.45	4
5	Nurse Aides & Orderlies	63,015	68,810	639,911	9.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,130	6,761	179,325	26.52	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,156	7,780	64,552	8.30	10
11	Social Service Workers	2,999	3,479	57,515	16.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,284	17,712	148,889	8.41	15
16	Dishwashers					16
17	Maintenance Workers	1,948	2,119	33,853	15.98	17
18	Housekeepers	9,469	10,297	87,747	8.52	18
19	Laundry	3,849	4,185	30,729	7.34	19
20	Administrator	3,348	3,348	112,305	33.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,568	8,934	111,000	12.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,073	2,258	26,771	11.86	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,272	170,007	$ 2,172,107 *	$ 12.78	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	13,200	Line 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,200		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	7	68	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	7	$ 68		53

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Scharp	Administrator	0	$ 112,305
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,305

B. Administrative - Other

Description	Amount
Home Office	$ 243,175
TOTAL (agree to Schedule V, line 17, col. 3)	$ 243,175
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Pacey & Pacey Lawyers	Legal	140
Retzke & Associates	Spec Consultant	1,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,140

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,117
Unemployment Compensation Insurance	23,364
FICA Taxes	165,515
Employee Health Insurance	224,482
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	17,557
Payroll Overhead Allocated	0
401K	11,552
Employee Uniforms	3,661
Home Office Allocation	32,994
TOTAL (agree to Schedule V, line 22, col.8)	$ 552,242

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 275
Advertising: Employee Recruitment	9,242
Health Care Worker Background Check	
(Indicate # of checks performed 34)	672
Dues & Subscriptions	2,931
Association Dues	3,952
Advertising	24,919
Less: Non-Allowable Association Dues	(1,191)
Less: Public Relations Expense	( )
Non-allowable advertising	(21,658)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,142

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	23,030
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	25
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,055

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON # 0041640 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HEARTLAND HLTH CR CTR-PAXTON **#** 0041640 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3,952**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,706** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **47,633**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,426**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.